Dr. Elvira Lindwall

Phone: (805) 370-1965
Fax: (805) 370–1984
2230 Lynn Rd. Suite 330
Thousand Oaks, CA 91360
Billing: (800) 626-2468

Dear Patient:

Thank you for choosing Dr. Lindwall for your Rheumatology care. In order to expedite the check in process, please review and complete all enclosed documents prior to your appointment. Please bring your completed forms, insurance cards, driver's license, and copies of any recent laboratory tests or imaging reports. You may, if easier for you, have them faxed to our office before your scheduled appointment.

You will receive a confirmation call from our office for each appointment the day before so please make sure to provide accurate contact information and report any changes as soon as possible. Each appointment time is scheduled for one patient in an effort to provide appropriate attention and care. Please provide our office with at least a 24-hour notice should you need to cancel or reschedule your appointment. If you miss an appointment without giving advanced notice, you will be charged up to $50 for each missed appointment.

If you have an insurance policy that requires an authorization or referral from your primary care physician, it is your responsibility to obtain one. Please make sure you have a valid referral for each visit.

Co-payment amount, if applicable, will be collected at the beginning of each visit. We accept cash, check, Visa and MasterCard. Please note that a $25 fee will be charged for any bounced or cancelled checks.

Our provider will not be able to provide care for any patient who declines to sign the Medical Services Agreement and Privacy Practices Form.

We look forward to meeting you and assisting you with your medical needs. Please contact our office should you have any further questions or concerns.

Sincerely,

Dr. Lindwall and staff

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OFFICE HOURS

Monday – Thursday: 8:30 am to 5:00 pm
Friday: 8:30am to 12:00pm
We are CLOSED for lunch from 12:00 pm to 1:30 pm
Phones are open from 8:30 am to 12:00pm and 1:30 pm to 5:00 pm

SCHEDULING APPOINTMENTS

Call our office during normal phone hours to make an appointment.
Any patient 15 minutes (or more) late will forfeit their appointment and will need to reschedule for a later date.
There is a $50 charge for missed appointments and appointments not cancelled at least 24 hours in advance.

PRESCRIPTIONS

For any **new** prescriptions, please call the office with medication name, dosage, directions and your pharmacy's name and phone number.
For all refills, have the pharmacy fax over a refill request form.
For any controlled substance prescriptions, please give a 72 hour notice before the fill date.

MEDICAL RECORDS AND FORMS

All requests for medical records made by another healthcare provider will be faxed to the requesting provider free of charge.
Patient requests for medical records will incur a $25 charge.
Disability forms may be completed (at the discretion of Dr. Lindwall) for a fee of $25-$50.

BILLING

For all billing---related questions, please call 800-626-2468.
We accept cash, check, Visa, and MasterCard.
All copays are due at the time of service.
For self-paid patients, all balances are due at the time of service.

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MEDICAL SERVICES AGREEMENT

Patient's Name: ____

1. **MEDICAL CONSENT**: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x---ray examinations provided to me under the general and special instructions of the physician, staff, or other health care providers of Dr. Lindwall MD a Medical Corporation (Dr. Lindwall) assisting my care.
2. **FINANCIAL AGREEMENT: I understand that all charges are due at the time of service.** I agree to pay for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. If I am a non---insured patient, I agree to pay for my visit in full at the time of service. If the provider is a participating provider with my insurance company I understand that my co---pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.

I understand that my insurance policy is a contract between myself and my insurance company; Dr. Lindwall is not involved. In order for Dr. Lindwall to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that Dr. Lindwall will need to verify my health insurance coverage. In the event that Dr. Lindwall is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. **INSURANCE AUTHORIZATION AND RELEASE:** I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to Elvira Lindwall M.D. a Medical Corporation for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Dr. Lindwall to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of Dr. Lindwall's charges, including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize Dr. Lindwall to act as my agent to help me obtain any required pre---certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Dr. Lindwall any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.
4. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize Dr. Lindwall to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.
5. **PERSONAL VALUABLES:** Dr. Lindwall shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

Elvira Lindwall M.D. a Medical Corporation and the patient or the patient's representative, hereby enters into this agreement.

The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

____

Signature of Patient Date or Signature of Patient's Representative & Relationship Date

______________________________ ______________________________

Office Representative Signature Date

Dr. Elvira Lindwall

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Patient Registration

Last Name: ________________________ First Name: ________________________MI: _____
DOB: __________________________ Social Security #: ______________________________
Address: __________________________City: _________State: ____________ Zip: ________
Primary Phone Number: ____________ Secondary Phone Number: ____________________
Driver's License Number: ___________________ Issuing State: ________________________
Employer:___________________________ Occupation: _______________________________
Email Address: ____

Emergency Contacts:
1. Name: ___________________ Relationship: ___________ Phone Number: ____________
2. Name: ___________________ Relationship: ___________ Phone Number: ____________

Primary Care Physician: ________________ Phone Number: ________________________

Who referred you to Dr. Lindwall? ________________________________

Primary Insurance Coverage:
Company: _________________ Effective Date: ___________ Group Number: ____________
Policy Number: ____________ Phone Number: _____________________________________

Secondary Insurance Coverage:
Company: _________________ Effective Date: ___________ Group Number:_____________
Policy Number: _____________ Phone Number:____________________________________

If you are covered under the policy of a spouse, partner, parent or legal guardian, please complete the following information:
Last Name: _________________________ First Name: _____________________ MI:_______
DOB: ____________________________ Social Security #:______________________________
Address: _______________________ City: State: _________________________ Zip: _______
Primary Phone Number: _______________ Secondary Phone Number: _________________
Employer: ___________________________ Occupation: ______________________________

Assignment of Insurance Benefits and Authorizations for Release of Information.

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Elvira Lindwall M.D. a Medical Corporation for any services furnished to me. I authorize any holder of medical information needed to release to the Health Care Financing Administration, its agents and/or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

____
Signature of Patient **Date**

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RHEUMATOLOGY PATIENT HISTORY FORM

Date: _______/_________/________

NAME: ____ Birthdate: _____ / _____ / ______
Last First M. I.

Age:___________ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? ____

Name of your primary care physician: ____

Describe briefly your present symptoms:

____
____
____
____

When did your symptoms start?

____
____

What diagnosis have you been given, if any?

____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:

Left Right Left

Left Right

Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

Please list the names of other practitioners you have seen for this problem:

____
____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

____
____
____
____

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RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative →	Name/relationship
Arthritis (type unknown)	❑	❑ →	______________________
Osteoarthritis	❑	❑ →	______________________
Rheumatoid arthritis	❑	❑ →	______________________
Gout	❑	❑ →	______________________
Lupus or "SLE"	❑	❑ →	______________________
Ankylosing spondylitis	❑	❑ →	______________________
Childhood arthritis	❑	❑ →	______________________
Sjogren's syndrome	❑	❑ →	______________________
Osteoporosis	❑	❑ →	______________________
Psoriasis/psoriatic arthritis	❑	❑ →	______________________

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) ___________________
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems

❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones

❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other significant illnesses (please list): ____

Previous Operations

	Type	*Year*	*Reason*
1.	____________________	________	______________________________
2.	____________________	________	______________________________
3.	____________________	________	______________________________
4.	____________________	________	______________________________
5.	____________________	________	______________________________
6.	____________________	________	______________________________
7.	____________________	________	______________________________

Any previous fractures? ❑ No ❑ Yes : Describe ____

Any other serious injuries? ❑ No ❑ Yes : Describe ____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: __________ How much: _______________________

Do you smoke? ❑ No ❑ Yes : In the past – How long ago?: __________

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _________________

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? ____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week ______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability?_______________________________________

What date did this disability begin? _____________

With whom do you currently live? ____

How much exercise do you get each week? __________ What kind of exercise? _________________________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: ________ Number living _________

Number of children ________ Number living _________ List ages of each ________________________

Health of children: ____

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SYSTEMS REVIEW

Date of last eye exam _________________ Date of last chest x-ray ________________
Date of last bone density test______________
Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: ___________

GENERAL
❑ Recent weight gain; how much____
❑ Recent weight loss: how much____
❑ Fatigue
❑ Weakness
❑ Fever
❑ Night sweats

MUSCLE/JOINTS/BONES
❑ Morning stiffness
Lasting how long ____ Minutes
____ Hours
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling
List joints affected in the last 6 months

____

____

EARS
❑ Ringing in ears
❑ Loss of hearing

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness
❑ Feels like something in eye

MOUTH
❑ Sore tongue
❑ Bleeding gums
❑ Sores in mouth
❑Loss of taste
❑ Dryness
❑ Recent increase in tooth cavities

NOSE
❑ Nosebleeds
❑ Loss of smell

THROAT
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Pain in jaw while chewing

NECK
❑ Swollen glands
❑ Tender glands

HEART AND LUNGS
❑ Pain in chest
❑Irregular heart beat
❑ Sudden changes in heart beat
❑ Shortness of breath
❑ Difficulty in breathing at night
❑ Swollen legs or feet
❑ Cough
❑ Coughing of blood

STOMACH AND INTESTINES
❑ Nausea
❑ Heartburn
❑ Stomach pain relieved by food
❑ Vomiting of blood/"coffee grounds"
❑ Yellow jaundice
❑ Increasing constipation
❑ Persistent diarrhea
❑ Blood in stools
❑ Black stools

KIDNEY/URINE/BLADDER
❑ Difficult urination
❑ Pain or burning on urination
❑ Blood in urine
❑ Cloudy, "smoky" urine
❑ Pus in urine
❑ Discharge from penis/vagina
❑ Frequent urination
❑ Getting up at night to pass urine
❑ Vaginal dryness
❑ Rash/ulcers
❑ Sexual difficulties
❑ Prostate trouble

BLOOD
❑ Anemia
❑ Bleeding tendency

SKIN
❑ Easy bruising
❑ Redness
❑ Rash
❑ Hives
❑ Sun sensitive
❑ Skin tightness
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
❑ Fainting or loss of consciousness
❑ Numbness or tingling in hands/feet
❑ Memory loss
❑ Muscle weakness

PSYCHIATRIC
❑ Depression
❑ Excessive worries
❑ Difficulty falling asleep
❑ Difficulty staying asleep

For women only:
Age when periods began: ___________
Number of pregnancies: ____________
Number of miscarriages: ____________
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: ____________
Date of last mammogram: ___________

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _________

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Authorization for Disclosure of Confidential information

Patient Name: ____

DOB: ____

Address:____

I,______________________________ authorize the release of my protected health information including results of my laboratory tests, X-rays and /or other test results to the following designated representative(s)

Patient Initials

__________ My Spouse (Name) ______________________________

__________ My Child (Name) ______________________________

__________ Others (Name) ______________________________

__________ May be left on my answering machine at home

__________ May be left on my answering machine at work

__________ May be left on my cell phone at: ______________________________

__________ **May not be given to anyone other than myself**

____
(Date) (Signature of Participant)

____
(Date) (Witness)

This authorization shall be valid for one year from the date of signature above unless revoked in writing by the patient prior to that expiration. As a patient, you have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization or, if applicable, during contestability period. In order for revocation of this authorization to be effective, Elvira Lindwall MD a Medical corporation must receive the revocation in writing. The Revocation must include 1) the patient's name, address, and date of birth. 2) Patient's desire to revoke the authorization. 3) Date of revocation and the patient signature. All revocation must be sent in writing to the attention of Elvira Lindwall MD a Medical Corporation Privacy officer at 2230 Lynn Rd. Suite 330 Thousand Oaks, CA 91360. Phone: (805) 370-1965 and Fax: (805) 370-1984.

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Patient Electronic Communication Consent

Elvira Lindwall MD a Medical Corporation is dedicated to keeping your medical record information confidential. To better serve our patients, our office has established a patient portal for some forms of electronic communication. Despite our best efforts, due to the nature of the patient portal and email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email and internet usage corporate property and your messages and internet usage may be monitored. Even when emailing from home, you may feel that access to your email and internet usage is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your physician, the staff and/or colleagues would have access to this information.

When sending mail, please put the subject of your message so we can process it more efficiently. Also, include your name and return telephone number in the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above electronic communication policy.

By signing below, I am agreeing that Elvira Lindwall a Medical Corporation may send medical related correspondence to me via electronic communication, and that we may respond to your electronic communication to us via electronic communication.

__________________________ __________________________________
Patient Signature Witness (optional)

__________________________ __________________________________
Patient Name Date of Birth

____
Date

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CONSENT TO RELEASE MEDICAL RECORDS

Patient name: ____Home Number: ______________________

Date of birth: __________________________________Cell Number: ____________________________________

I hereby authorize and request that____
Name of facility/individual

____
Address City/State/Zip

Release information from my records to the following:

Name of the Facility/individual: _Dr. Elvira Lindwall ___________ Fax Number, if applicable _(805) 370-1984_

___2230 Lynn Rd. Suite 330 Thousand Oaks, CA 91360____
Address City/State/Zip

Please be specific regarding record and dates requested information to be released

- ☐ Diagnosis and record of treatment ____
  Specific date / dates requested
- ☐ Laboratory and/or X-ray reports ____
  Specific date / dates requested
- ☐ Entire file (excluding confidential and psychiatric records, if any)
- ☐ Other ____

BE ADVISED THAT IF YOU ARE REQUESTING A COPY OF YOUR MEDICAL RECORD, A COPYING FEE MAY APPLY. IT IS PROHIBITED BY LAW TO RELEASE/DISCLOSE THE ATTACHED/ENCLOSED INFORMATION TO ANYONE EXCEPT THOSE SPECIFIED ABOVE. I UNDERSTAND THAT THIS AUTHORIZATION ALONE MAY NOT AUTHORIZE RELEASE OF PSYCHIATRIC OR HIV INFORMATION.

► In signing, I am aware that this Authorization is valid for 30 calendar days after today.

► Signature: ____ Date: __________________

If a minor; signature, name and date of parent/guardian: Signature: ________________________________

Date: ___________________________________ Name: ____